

Please return report to:



City of Wenatchee, Environmental Division

Attn. Julie Michael, Quality Control Technician

P.O. Box 519, 1350 McKittrick Street

Wenatchee, WA 98807-0519

509-888-3227 or Fax 509-888-3201

BACKFLOW PREVENTION ASSEMBLY TEST REPORT

ACCOUNT #:

Test Due Before:

NAME OF PREMISE:

Commercial ☐ Residential ☐

SERVICE ADDRESS:

CITY:

ZIP:

PHONE:

LOCATION OF ASSEMBLY:

DOWNSTREAM PROCESS:

DCVA ☐ RPBA ☐ PVBA ☐ OTHER _____

NEW INSTALL ☐ EXISTING ☐ REPLACEMENT ☐ OLD SER. # _____ PROPER INSTALLATION? YES ☐ NO ☐

MAKE OF ASSEMBLY:

SERIAL #:

IS THIS ASSEMBLY ON THE LIST OF ASSEMBLIES APPROVED FOR USE IN WASHINGTON STATE? _____

INITIAL TEST	<u>DCVA / RPBA</u> <u>CHECK VALVE NO.1</u>	<u>DCVA / RPBA</u> <u>CHECK VALVE NO.2</u>	<u>RPBA</u>	<u>PVBA/SVBA</u> <u>AIR INLET</u>
	LEAKED <input type="checkbox"/> CLOSED TIGHT <input type="checkbox"/> _____PSID	LEAKED <input type="checkbox"/> CLOSED TIGHT <input type="checkbox"/> _____PSID	OPENED AT _____PSID #1 CHECK _____PSID AIR GAP OK? _____	OPENED AT _____PSID <u>OPENED FULLY</u> <input type="checkbox"/> CHECK VALVE HELD AT _____PSID
NEW PARTS AND REPAIRS	CLEAN REPLACE PART <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____	CLEAN REPLACE PART <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____	CLEAN REPLACE PART <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____	CLEAN REPLACE PART <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> _____
	TEST AFTER REPAIRS	CLOSED TIGHT <input type="checkbox"/> _____PSID	CLOSED TIGHT <input type="checkbox"/> _____PSID	OPENED AT _____PSID #1 CHECK _____PSID

SHUT OFF VALVES CLOSED TIGHTLY?

SOV #1

yes ☐ no ☐ n/a ☐

SOV #2

yes ☐ no ☐

AIR GAP INSPECTION: Required minimum air gap separation provided? Yes ☐ No ☐ Detector Meter Reading _____

REMARKS: _____ LINE PRESSURE _____PSI

_____ CONFINED SPACE? _____

I certify that this report is accurate, and I have used WAC 246-290-490 approved test methods and test equipment.

TESTERS SIGNATURE: _____ CERT. NO. _____ DATE _____

TESTERS NAME PRINTED: _____ TESTERS PHONE # () _____

REPAIRED BY: _____ DATE _____

FINAL TEST BY: _____ CERT. NO. _____ DATE _____

CALIBRATION DATE __ / __ / __ GAUGE # _____ MODEL _____ SERVICE RESTORED? YES ☐ NO ☐